Patient Classification Tool

Long Term Care Development Projects

PATIENT CLASSIFICATION PROJECT PROGRESS REPORT NO. 8

MAY 1989

Patient Classification Funding System To Take Effect April 1

We are pleased to announce that $12 million in additional funding has now been allocated for increased nursing care services in long-term care facilities for the 1989-90 fiscal year. The new funding, based on patient classification, is effective April 1, 1989.

The department continues to work with the Patient Classification Consultation Group on the new funding system and related issues. The members of the Consultation Group are:

AHA:
- Bill Dainard
- Phil Gaudet
- Shirley Morie
- Mike Ostafichuk
- Werner Pauls
- John Vogelzang
- Gordon Voth
- Denise Walters

ALTCA:
- Rich Bayly
- Carl Bond
- Wayne McKendrick
- Paul Rushforth
- Gregg Ulveland

DEPT:
- Bev Jaap
- Vivien Lai
- M. (Scotty) Lamb
- Rulon Meldrum
- Don Philippon
- Corinne Schalm

At its last meeting, the Consultation Group was presented with details of the new funding system. The committee supported the methodology and recommended implementation effective April 1, 1989. The new funding system will be implemented as follows:

1. Each facility's current global budget/per diem rate is its base.
2. The base budget is split into nursing care and support (all non-nursing) services components. The nursing care component includes direct resident care services only.
3. The base operating grants (global budget/per diem rate) and specific program grants are indexed by 5%.
4. Facilities with a higher case-mix index in relationship to current funding will get patient classification additional funding. This case-mix index funding will apply *only* to nursing care costs. The current methods of funding support services will remain as is.
5. The heavy care program for nursing homes will be discontinued as this was an interim measure only.

In order to assist nursing homes to meet the needs of heavy care residents and to facilitate the implementation of the new funding system, a number of changes are being made to the Nursing Homes Operation Regulations. Funding will be provided to meet these new requirements. Directives have been sent to each

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nursing home outlining the following changes which are effective April 1, 1989:

1. Extension of 24 hour R.N. coverage to all nursing homes. (At present this is not required for nursing homes under 90 beds.)
2. Increase of the minimum R.N. percentage of nursing care hours from 16% to 22%. The department is increasing per diems by $1.00 to reflect the cost of this changed requirement.
3. Increase of the minimum nursing administration time to .5 F.T.E. for facilities with fewer than 40 beds. (Those with 40 beds and over are already required to provide more than .5 F.T.E. nursing administration time.)
4. Payment of a per diem for a bed held for up to five days after a potential resident has been notified and is making a decision and/or preparing to enter the nursing home.
5. Conversion of the 1.65 worked nursing hours per resident day requirement to the equivalent 1.90 paid hours to facilitate comparison with auxiliary hospital reporting. This change in measurement methodology does not represent a change to the basic level of care to be provided.

The Consultation Group will conduct a post-implementation review of the new system to determine if any modifications are required. It will also continue to plan and implement current and future projects associated with moving towards an integrated long-term care system:

- a policy on oxygen use in nursing homes,
- broadening of admission criteria for nursing homes, and
- addressing the major program differences between nursing homes and auxiliary hospitals.

Alberta Health is committed to an open and flexible process with all parties working together. We want to ensure that the new system best meets the needs of the long-term care system as a whole. The department and your representatives on the Consultation Group welcome your input over the next few months as we all begin to work with this new system.

Classification Results Are In!

The results from the first province-wide patient classification are now in. The results are based on the Fall 1988 classifications of 12,257 residents, which represent 94 percent of all nursing home and auxiliary hospital beds in the province.

Residents were not classified if:

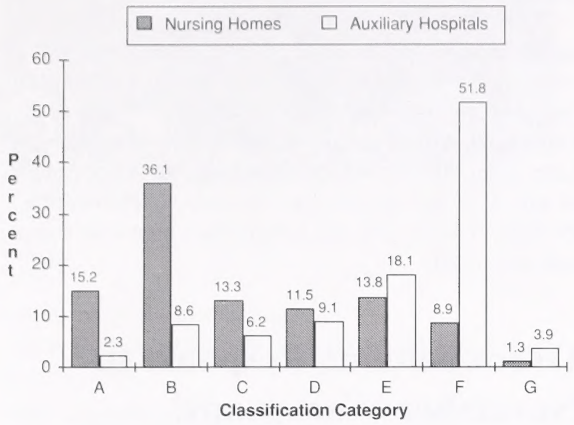
- they had been admitted less than three weeks prior to the facility's classification period;
- they were not in the facility at the time of classification and had been absent for more than 24 hours (i.e. were on a leave of absence or were temporarily transferred); or
- their chart was not on the facility premises and could not be retrieved before the classifier(s) left (e.g., resident was receiving treatment at the Cross Cancer Institute that day).

Facilities should now have received the classification results for their residents and for the province as a whole. This is how residents were distributed among the seven classification categories:

Classification Category	Percentage of Residents
A	10.1
B	25.3
C	10.5
D	10.5
E	15.5
F	25.8
G	2.3
	100.0

The new data are consistent with the previous (1986 and 1987) studies in demonstrating that the full range of classification categories appear in both the nursing home and auxiliary hospital systems. It also confirms that nursing homes concentrate more on the lower care categories (A-E in this year's distribution) and auxiliary hospitals specialize in heavier care (categories E-G). A comparison is presented on the next page.

Comparison of Percentage of Residents in Each Classification Category in 1988: Nursing Homes versus Auxiliary Hospitals



Some findings of interest include the following:

- The average age of auxiliary hospital residents is 79.4. The average age of nursing home residents is 83.2.
- 65.3 percent or almost two-thirds of long-term care residents in Alberta are female.
- 13.5 percent of the 12,257 individuals classified were never married; 22.9 percent are currently married; and 63.6 percent are widowed, divorced or separated.
- The preferred language of 79.3 percent of long-term care residents is English. Ukrainian and German are the next two most preferred languages, at 6.9 and 4.0 percent, respectively.
- The most common psychosocial aspects requiring staff attention are resident depression and withdrawal.
- 45 percent of residents have some degree of communication impairment.
- The average total number of medications (different drugs, not number of doses) taken per day by each resident is 4.7. The lowest facility average per resident at the time of classification was 2.6.
- 70 percent of residents receive assistance from family and/or friends on at least a weekly basis.

As shown above, Alberta now has its first comprehensive information base on long-term care residents. The data will be extremely valuable in planning programs and policies to meet resident needs. The province will also be able to track trends over time and identify areas in which policy changes may be required. This information base is perhaps one of the most significant side benefits of the classification data. The department will provide facilities with resident profile statistics on request.

First Province-Wide Classification A Success

The task of classifying a potential 13,000 long-term care facility residents...who were spread across 167 facilities...within a two month time period...for the first time ever in this province, was a challenge to say the least. This challenge was met by the consulting firm of Medicus Canada and 49 nurse classifiers (Patient Classification Consultants) recruited by Medicus. All of the classifiers were experienced in long-term care and most were "loaned" to Medicus by facilities in the province. None of these nurses were permitted to classify in a facility which was owned or operated by their employer.

The classifiers were tested for reliability twice a month during the classification period of September — October. Their level of agreement was very high, exceeding 99 percent. That is, the classifier and an independent reliability tester arrived at identical classifications over 99 percent of the time. The department of Health therefore has a lot of confidence in the data itself.

Some facilities have tried using the Patient Classification Form on their own for internal management purposes. It should be stressed that the

Classifiers at Edmonton debriefing
... hard work paid off

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Calgary debriefing session
... Medicus, mousetraps and memories

Medicus classifiers were able to achieve their high level of reliability only after successfully completing an intensive four day training session. It is extremely important that classifiers interpret the Form's classification indicators in the same manner to ensure accuracy and consistency across the province.

Facilities were asked to evaluate the classification process. An amazing 99.9 percent of the respondents said that they were "generally pleased with the project as it was carried out at [their] facility." Medicus reported that, "one of the most frequent comments...was the importance and value placed on having (the classification conducted by) nurses who worked in and/or understood the long-term care environment. Frequent mention was made (regarding) their understanding of the pressures on nursing staff, their appreciation of unit routines, and their general familiarity with long-term care facilities."

These classifiers and the organizations they represent are to be commended for the manner in which they conducted themselves. They were described as: approachable, flexible, knowledgeable, efficient, pleasant, cooperative, willing to answer questions, professional, well organized, friendly, courteous, and not disruptive to regular care routines.

Classifiers in Calgary
... praised for being flexible, professional, organized

When it was all over, the classifiers met for a half day debriefing session in which they provided invaluable suggestions in areas such as training and project organization and management, and clarifications to the Patient Classification Form and instruction manual. Later, over dinner, they voted on who had the best story to tell (what was the one about the mousetraps under all the beds in the hotel?) and agreed that a memorable time was had by all.

Overwhelming Response to November Workshops!

Standing room only at workshops
... 96% of participants were impressed

Registration in November's workshops exceeded all expectations—in fact a second session had to be scheduled in Edmonton to meet the demand. Close to 700 facility administrators, board members and nursing, finance and rehabilitation staff attended workshops in St. Paul, Red Deer, Lethbridge, Grande Prairie, Calgary and Edmonton.

The morning workshop session (an overview of the funding system concepts) was videotaped for future instruction. Copies of the video can be borrowed from the Long-Term Care Inservice Resource Centres, the Alberta Hospital Association and the Alberta Long Term Care Association. There are also extra packages of workshop handouts available on request from the address provided at the end of this progress report.

The afternoon session began with what was generally

A quick break for the speakers
... (L to R) Rulon Meldrum, Don Philippon, Vivien Lai

a very animated question and answer period. The most common questions and answers are being published in "You Asked Us," a new addition to the Patient Classification progress report. See page 5 for the first feature.

Evaluation forms were completed by participants at each workshop. The overall response was extremely positive. 96 percent of respondents felt the workshop was helpful in increasing their understanding of the funding system. 76 percent supported the concepts of the funding system proposal based on (1) its equity across the system, and (2) the anticipated resident benefits. The remaining 24 percent requested more information.

This feedback was very helpful, and we thank all those who took the time to complete a workshop evaluation form. Thanks to all of you who attended and for the positive reinforcement you provided at the workshops!

You Asked Us

This new section will become a regular feature in the progress report. Seven workshop sessions across the province generated some excellent questions, so we will attempt to publish a selection in each issue. If you have additional questions, please feel free to write.

1. How often will classifying be done and who will be doing it?

How often?

To answer these questions, the department consulted with other provinces and states. It was then decided that province-wide classifying in Alberta will be conducted once a year for all long-term care residents, with a mid-year classification for new residents. Other jurisdictions using a patient classification funding system have found that changes in overall case-mix occur very gradually, thus annual classification is considered to be the most cost effective and administratively manageable. It also creates an incentive to maintain or improve residents' level of functioning since funding does not change for twelve months except for new admissions.

Who?

The three options for classifying responsibility are: 1) facility staff with a government audit system, 2) an external group, or 3) government staff. A combination of options 1 and 2 was chosen for the first province-wide classification: Medicus Canada was contracted to manage the project with facility staff hired as classifiers.

After reviewing all the facility evaluations and meeting with the 49 classifiers in debriefing sessions, Medicus recommended that future management of the data collection be contracted out and that a core group of nursing staff be selected and trained to complete data collection. The rationale was as follows.

First, classifiers must complete a four day training session to ensure that data interpretation and comparison are consistent throughout the province. It would not be practical to train all facility staff in Alberta for a process which may only take a day or two a year in smaller facilities. Second, it is more difficult to control reliability and manage data for two or three hundred

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classifiers as opposed to a smaller core group. Finally, classifiers overwhelmingly stated that they feared a loss of objectivity if they had to classify residents in their own facilities.

Still, no final decisions have been made on the procedure for the second province-wide classification. We welcome your input.

2. Why were bathing and grooming not included in the Patient Classification Form when these activities take so much nursing time? Will they be funded in the new system?

These activities were included in the original version of the Patient Classification Form (PCF) which was tested in the 1986 Provider Activity Study. The goal of that study was to find the fewest number of indicators which could predict variations in care requirements. Based on the results of the study, bathing, grooming and a number of other items were excluded from the final version of the PCF.

Grooming was not included because it turned out to be redundant with dressing and not as reliable—not everyone agrees on what constitutes good grooming habits! Bathing was deleted because there was little variation across residents: 95 percent were assessed as requiring total assistance or constant supervision when bathing. With all residents scoring virtually the same on bathing, this indicator doesn't help distinguish between the seven classification categories. It seems the bathing indicator was really measuring institutional policies regarding safety issues, not functional status.

It is important to note that while bathing, grooming and many other activities are not included in the PCF and are not necessary for classifying a person, the time it takes to perform these activities ***was*** included in each category nursing weight. These activities will continue to be funded in the new funding system.

3. Why was recreation therapy not included in the Patient Classification System? Will it continue to be funded in the future?

The largest single component of government funding for long-term care facilities is nursing care services. While the Alberta classification system attempted to go one step further and include physical and occupational therapy, recreation therapy needs do not increase with classification category. In fact, recreation may have a negative correlation with nursing: lower classification categories use ***more*** recreation time. Thus for the present time it seems more appropriate to continue to fund recreation therapy based on number of residents.

Other classification systems in North America have tried to incorporate rehabilitation requirements without success. The department is continuing to look at this area for possible future development.

Copies of this and previous Patient Classification Project progress reports may be obtained from:

Corinne Schalm, Patient Classification Coordinator
Long Term Care Institutions Branch

Alberta Health
6th Floor, Hys Centre
11010 - 101 Street
Edmonton, AB
T5J 2P4
Telephone: 427-7128